Carpenters Health and Welfare Trust Fund for California
Revoke/Terminate a Prior Authorization

265 Hegenberger Rd, Suite 100 * PO Box 2280, Oakland, CA 94621
Tel. (510) 633-0333 * (888) 547-2054 * Fax (510) 633-0215

Name: _____ SSN, CFAO ID#, or UBC#: _____

I, _____ , hereby **revoke/terminate** an authorization that I made on _____ , 20_____ regarding the use or disclosure of my health information.

1. Specific person/organization (*or class of persons*) who was authorized to **provide** the information:

   _____

2. Specific person/organization (*or class of persons*) who was authorized to **receive** and use the information:

   _____

3. Specific **description of the information that was allowed to be used or disclosed**.

   (Include dates as appropriate):

   _____
   _____
   _____

4. I understand that the revocation/termination is only effective **after** it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the date of this revocation/termination will not be affected by this revocation/termination request.

_____ _____
Signature of Individual **Date**

or

_____ _____
Signature of Personal Representative **Date**

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of:

- ❑ A signed Personal Representative Form;
- ❑ Other: _____

Acknowledgement by the Privacy Officer: _____

Date: _____